Missouri Department of Health and Senior Services
Missouri Radiation Control Program
Out-of-State *Radiation Machine* Registration Form

I. CONTACT INFORMATION: DATE:_____

USER NAME:_____

Requested start date for use_____ Stop Date_____ Duration of use_____

Location/address of use _____

_____

_____

Telephone # (___)_____Fax # (___)_____

Description of site:_____

_____

Machine use:_____

_____

II. RADIATION MACHINE INFORMATION:

Owner Name/Company:_____

Manufacturer:_____

NRC/AS license number:_____

Model number:_____ Serial number:_____

Maximum kVp:_____ Maximum mA:_____

Owner Signature:_____

Owner Printed Name:_____

Send information to:
Missouri Department of Health and Senior Services
Missouri Radiation Control Program
P.O. Box 570 1617 Southridge Dr.
Jefferson City, MO 65102
Phone # (573) 751-6083 Fax # (573) 751-6158

DHSS/MRCP Use Only

Approval Signature_____Date:_____